DISPROPORTIONATE SHARE HOSPITAL
OBSTETRICIAN AVAILABILITY CERTIFICATION

HOSPITAL: _____

ADDRESS: _____

_____

_____

I hereby certify that _____, hereinafter designated the "Hospital," either (check the appropriate box below):

☐ **has at least <u>two</u> obstetricians with <u>staff privileges</u> at the Hospital who have agreed to provide obstetric services to Medi-Cal patients. Please list the names of these obstetricians on the attachment entitled "List of Obstetricians Providing Medi-Cal Obstetrical Services". Failure to maintain a minimum of two obstetricians who will accept Medi-Cal patients will subject the Hospital to lose this additional reimbursement and recoupment of any funds received inappropriately; or**

☐ **provides inpatient services to predominately individuals under 18 years of age; or**

☐ **does not offer routine obstetric services to the general population as of December 22, 1987.**

Name: _____

Title: _____

Signature: _____

Date: _____

Telephone: _____

E-Mail Address (Optional): _____

NOTE: Failure to submit or omit the above designation on this form can cause the hospital to not receive any scheduled DSH payments in the future. If for any reason, this list should no longer be correct, the Hospital must submit a corrected list to the Department of Health Care Services – Disproportionate Share Unit.

LIST OF OBSTETRICIANS PROVIDING MEDI-CAL OBSTETRICAL SERVICES

Date: _____

Hospital: _____

Obstetrician Name	Office Address	Telephone Number